MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

930 04115

Reg. Dist. No. 190

1. PLACE OF DEATH:

County: Howard

City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, Institution, or street address where death occurred: Athol & Forestave, Howard

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Howard

City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. Athol & Forestave, Howard
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Nora Gertrude Anderson

3.(b) Social Security Number: 220-22-1173

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Richard T. Anderson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 2 1896

8. AGE: Years: 51 Months: 3 Days: 8 If less than one day: ..... hrs. ..... min.

9. Birthplace: Jessup Md (Town, county, and state)

10. Usual occupation: Saleslady

11. Industry or business: Stewart & Co.

FATHER — 12. Name: Edward T. Anderson

FATHER — 13. Birthplace: Howard Co. Jessup Md

MOTHER — 14. Maiden name: Elizabeth Hardner

MOTHER — 15. Birthplace: Harford Co. Aberdeen Md

16. Informant: Mrs. Alice Linder (Sister)

Address: Harwood Pk. Elkridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1947 (month) (day) (year)

Cemetery or crematory: London Park Cem.

Location: Frederick Ave. Baltimore

18. Funeral director: Easton Sons

Address: Ellicott City, Md.

19. May 12 1947 (Date rec'd by registrar) (miss) E. Bird Villers Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1947, at 3 12 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 7 1947 to May 10 1947

and that I last saw her alive on May 10 1947

Immediate cause of death	DURATION
Cerebral thrombosis	1 day
Due to: Arterial hypertension	3 yrs
Due to: General arterio-sclerosis	3 yrs
Other conditions: Hypertensive Heart disease (E.K.G.)	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. B. Brumbaugh M. D. or other

Address: Elkridge Md Date signed: 5/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04116

Reg. Dist. No. 195

1. PLACE OF DEATH:

County: Howard

City or town: Guilford

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Howard

City or town: Jessups / Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Guilford

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: FLORENCE BOSTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	married.

6.(b) Name of husband or wife: Albert Boston

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 10, 1876

8. AGE: Years: 70 | Months: 5 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: maryland (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER — 12. Name: David Thomas

13. Birthplace: md

MOTHER — 14. Maiden name: Mollie Hanson

15. Birthplace: md

16. Informant: Albert Boston

Address: Jessups md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-19-47 (month) (day) (year)

Cemetery or crematory: Asbury

Location: Annapolis Junction Md

18. Funeral director: F.P. Ney Unbotham

Address: Ellicott City md

19. 5/17/47, 19 (Date rec'd by registrar) Frank Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 19 47 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 31 19 47 to May 15 19 47 and that I last saw her alive on May 14 19 47

Immediate cause of death: Cerebral Hemorrhage — left hemiplegia — DURATION: 6 weeks

Due to: Hypertensive Cardio-Vascular Disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John Stephens M.D. M. D. or other

Address: Laurel, Maryland Date signed: May 15 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04117

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:
County: Howard.
City or town: Clarksville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months.
Hospital, Institution, or street address where death occurred: Dayton, Post Office.
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard.
City or town: Clarksville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Dayton Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: Margaret Lee Bright

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 14, 1927

8. AGE:

Years	Months	Days	If less than one day
19	11	2	..... hrs. ..... min.

9. Birthplace: Dayton, Howard Co, Md
(Town, county, and state)
10. Usual occupation: none
11. Industry or business: —

MOTHER FATHER
12. Name: William Bright
13. Birthplace: md
MOTHER
14. Maiden name: Stella Johnson
15. Birthplace: Md

16. Informant: Wm Bright.
Address: Dayton Post Office Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-47 (month) (day) (year)
Cemetery or crematory: Brown's Chapel
Location: Dayton, Md.
18. Funeral director: J.C. Higinbothom
Address: Ellicott City Md.

19. 5/18/1947 (Date rec'd by registrar) Marie C. Whitaker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1947 at 7 AM P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1947 to May 16 1947 and that I last saw h[illegible] alive on at no time 19....

Immediate cause of death	DURATION
Pulmonary Edema	10 min
Due to: Lobar Pneumonia	2 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Alpha N. Herbert M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address: Ellicott City Md. Date signed 5/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180 Registered No. 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hill Top Cabins, West. Blvd
(c) Hospital or institution: just north of Montgomery Co. Line, Howard Co.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 04118
(a) State (b) County unknown
City or town (If outside city or town limits, write RURAL and give town)
(c) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winnifred May Buchanan

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation unknown

11. Industry or business

FATHER
12. Name W J Wiggins
13. Birthplace Ind.

MOTHER
14. Maiden Name Anna Whiting
15. Birthplace Ohio

16 (a) Informant W. J. Wiggins
(b) Address Phillipsburg Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-47 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Ellicott City Md

18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md

19 (a) May 28, 47 (Date rec'd by registrar) (b) John B. Lynch Jr. Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1947, at 11:30 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH "Probable accident (5/26/47 mb)
Extensive third degree burns, covering practically all body surface
Due to Carbon monoxide poisoning
Rt. extradural hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 5/26/47

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 04119

Reg. Dist. No. 7H 190

1. PLACE OF DEATH:

County: Howard

City or town: Elkridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Howard

City or town: Elkridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Montgomery Road

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Godfrey Kelly

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Florence V. Shipley

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Feb. 15, 1860

8. AGE: Years	Months	Days	If less than one day
87	4	13	..... hrs. ..... min.

9. Birthplace: Eglon, W. Va. (Town, county and state)

10. Usual occupation: Prospector

11. Industry or business: Filling Station

FATHER

12. Name: John Kelly

13. Birthplace: Germany

MOTHER

14. Maiden name: Christine Hess

15. Birthplace: Germany

16. Informant: Mrs. Florence Kelly

Address: Elkridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31 1947 (month) (day) (year)

Cemetery or crematory: Meadowridge Memorial

Location: Washington Blvd.

18. Funeral director: C. Harry Weer

Address: Laytonsville, Md.

19. May 30 1947 (Date rec'd by registrar) C. Harry Weer Registrar

(Mrs.) E. Rhea Weer Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1947 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1947 to May 28 1947 and that I last saw h[illegible] alive on May 28 1947

Immediate cause of death	DURATION
Chronic Myocarditis	2 mo.
Due to: Senile Arteriosclerosis	2 yrs.
Due to: Hypertension	2 yrs.
Other conditions: Senility	2 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. B. Cumbaugh M. D. or other

Address: 5609 Main St Elkridge Md. Date signed: 5/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04120

CERTIFICATE OF DEATH

Reg. Diat. No. 191

1. PLACE OF DEATH:

County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Frederick Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Frederick Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma Amelia Green

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Walter J Green

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 2, 1888

8. AGE:

Years	Months	Days	If less than one day
58	7	17	..... hrs. ..... min.

9. Birthplace: Laurel md
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER

12. Name: Chas. E Clark

13. Birthplace: md.

MOTHER

14. Maiden name: Betty Stanton

15. Birthplace: md

16. Informant: Walter J Green

Address: Ellicott City md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-21-47 (month) (day) (year)

Cemetery or crematory: Hoy Hill

Location: Laurel Md

18. Funeral director: F O Diffenbaugh

Address: Ellicott City md

19. May 20 1947 (Date rec'd by registrar) John B. Laughran M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1947 at 6 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1947 to May 19 1947 and that I last saw h.. alive on May 19 1947

Immediate cause of death	DURATION
Coronary Occlusion	unk
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: John B Laughran M. D. or other

Address: Ellicott City md. Date signed 5/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117a

04121

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard

City or town Ellicott City (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Howard

City or town Ellicott City (If outside city or town limits, write RURAL and give nearest town)

Street No. Fells Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Grimes

3.(b) Social Security Number 213-12-2624

4. Sex M

5. Color or race C

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Alverta Grimes

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) May 1, 1902

8. AGE: Years 45 Months 0 Days 12 If less than one day ...hrs. ...min.

9. Birthplace Ellicott City Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Paper Box Mfgr.

FATHER 12. Name Chas Grimes

13. Birthplace Md

MOTHER 14. Maiden name Clara Dorsey

15. Birthplace Md

16. Informant Alverta Grimes

Address Ellicott City Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 5-15-47 (month) (day) (year)

Cemetery or crematory Western Star

Location Catonsville Md.

18. Funeral director F. C. Higinbothom

Address Ellicott City Md

19. May 15, 1947 (Date rec'd by registrar) John B. Loughran Per. B. E. L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1947, to May 12 1947 and that I last saw him alive on May 12 1947

Immediate cause of death	DURATION
Gastric Hemorrhage	acute
due to ulcer of stomach [7/2/47 ake]	probably 1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Ellicott City Md Date signed 5/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 04122 B

Reg. Dist. No. .....

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County HOWARD

City or town RURAL - ELLICOTT CITY

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? SINCE 4-21-1947

Hospital, institution, or street address where death occurred:

PINEL CLINIC - ELLICOTT CITY

How long in hospital or institution? SINCE 4-21-1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Balto

City or town SPARROWS POINT 19 MD

(If outside city or town limits, write RURAL and give nearest town)

Street No. 815 F. STREET

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME JAMES HANNA

3.(b) Social Security Number 215-100-388

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 21, 1893

8. AGE: Years	Months	Days	If less than one day
54			..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation .....

11. Industry or business Bethlehem Steel Corp.

FATHER 12. Name John Hanna

13. Birthplace Scotland

MOTHER 14. Maiden name Elizabeth McBride

15. Birthplace Scotland

16. Informant MR. J. B. MC CARDELL

Address 815 F. STR. SPARROWS POINT

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/22/47 (month) (day) (year)

Cemetery or crematory XXXX Oak Lawn

Location Eastern Ave., Baltimore, Md.

18. Funeral director Charles E. Schimunek

Address 2601-03 E. Madison Street

19. 5/21 19 47 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 19th 19 47 at 10 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 21 19 47 to MAY 19th 19 47 and that I last saw h.i.m. alive on MAY 19th 19 47

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	5 DAYS
Due to	.....
Due to	.....
Other conditions HYPOSTATIC PNEUMONIA	4 DAYS

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Helmut Prager M.D.

M. D. or other

Address Ellicott City Md Date signed 5/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04123

CERTIFICATE OF DEATH

Reg. Diat. No. 191

1. PLACE OF DEATH:

County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:
Frederick Rd & St Johns Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No. Frederick Rd & St Johns Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Rose Hedding

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Manchester, Md. 12/26/63

8. AGE:

Years	Months	Days	If less than one day
83	4	14	..... hrs. ..... min.

9. Birthplace: Manchester Md.
(Town, county, and state)

10. Usual occupation: Housekeeping

11. Industry or business

FATHER
12. Name: Anthony Hedding
13. Birthplace

MOTHER
14. Maiden name: Mary Yeager
15. Birthplace

16. Informant: Mr. Judson Boswell

Address: Ellicott City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14 1947 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Old Frederick Rd. Balto. Md.

18. Funeral director: Easton Sons

Address: Ellicott City, Md.

19. May 12, 1947 (Date rec'd by registrar) John B. Leughan Pro. R. E. L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1947 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-9 1947, to 5-10 1947 and that I last saw her alive on 5-10 1947

Immediate cause of death	DURATION
Coronary Thrombosis	24 hours
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: George E. Burgtorf M.D. M.D. or other

Address: Ellicott City, Md. Date signed 5-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93a

04124

CERTIFICATE OF DEATH

Reg. Diat. No. 195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Howard

City or town High Ridge (Laurel)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Laurel (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. High Ridge Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ada Bell Huddleston

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 7, 1883

8. AGE:

Years	Months	Days	If less than one day
64	-	22	..... hrs. ..... min.

9. Birthplace Missouri (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Gilbert Goad

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Dr. L. G. Huddleston

Address Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31, 1947 (month) (day) (year)

Cemetery or crematory ~~Ivy Hill Emmanuel~~

Location ~~Laurel~~, Md., Scaggsville, Rt.

18. Funeral director Leavitt Donaldson

Address Laurel, Md.

5/30/47 (Date rec'd by registrar) 18. ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1946 to May 27 1947 and that I last saw h.r alive on May 26 1947

	DURATION
Immediate cause of death Acute myocarditis	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S. McLaughlin M. D. or other

Address 40 Main St. Laurel Md. Date signed June 4/47

Middleton

04125 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County HOWARD

City or town RURAL - ELLICOTT CITY (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 MONTHS 15 DAYS

Hospital, Institution, or street address where death occurred: PINEL CLINIC

How long in hospital or institution? 3 MONTHS 15 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County BALTO CITY

City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give nearest town)

Street No. 700 NORTH ROSE STREET (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME ANNA LUDTMAN

3.(b) Social Security Number

4. Sex FEMALE

5. Color or race WHITE

6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife ——

6.(c) If alive, give age ...... years

7. Birth date of deceased (mo., day, yr.) MONTH + DAY NOT KNOWN 1873

8. AGE: Years 74 Months 2 Days 2 If less than one day ...... hrs. ...... min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual occupation ~~HOUSEWIFE~~

11. Industry or business At Home

FATHER

12. Name Dont Know

13. Birthplace Germany

MOTHER

14. Maiden name Dont Know

15. Birthplace Germany

16. Informant GODFREY STEINER

Address 5404 HAMLET AVE BALTO

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7 - 1947 (month) (day) (year)

Cemetery or crematory Parkwood Cem

Location Rural

18. Funeral director Ullrich Funeral Home

Address 2018 Orleans St

19. 5/6 1947 A. Hedrick D.R. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 3rd 1947, at 8 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEBRUARY 18th 1947, to MAY 3rd 1947

and that I last saw her alive on MAY 3rd 1947

Immediate cause of death	DURATION
MYOCARDIAL INFARCT	28 HOURS
Due to GENERALIZED ARTERIOSCLEROSIS	3 YEARS
Due to	
Other conditions FRACTURE OF NECK OF LEFT FEMUR (Include pregnancy within 3 months of death)	43 DAYS

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental fall Date of February 20th 1947

Where did injury occur? Pinel Clinic Ellicott City, Md (City or town) (County) (State) [7/2/47 abc]

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Helmut Prager M.D (M. D. or other)

Address Ellicott City Md Date signed 5/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

04126

CERTIFICATE OF DEATH

Reg. Dist. No. 2, 74

1. PLACE OF DEATH:

County Howard

City or town Alpha

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 6 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard

City or town Alpha

(If outside city or town limits, write RURAL and give nearest town)

Street No. Marriottsville P. O.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Macauley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1871

8. AGE: Years 76 | Months 3 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Belfast, Ireland (Town, county, and state)

10. Usual occupation Engineer

11. Industry or business Maritime

FATHER 12. Name Unk.

13. Birthplace

MOTHER 14. Maiden name Unk.

15. Birthplace

16. Informant Mrs. Adelaide Tribull

Address Marriottsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6, 1947 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Lyndsville, Md.

18. Funeral director C. Harry Weer

Address Lyndsville, Md.

19. May 5 1947 C. Harry Weer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 7 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1946, to May 4 1947

and that I last saw h... alive on May 7 1947

Immediate cause of death	DURATION
Cardio Vascular disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Barnes MD M. D. or other

Address Lyndsville Md Date signed 5/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04127

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:
County Howard
City or town Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Howard
City or town Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph J. McGivney

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1901

8. AGE: Years 46 | Months 4 | Days 3 | If less than one day hrs. min.

9. Birthplace Brookline Mass. (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

FATHER 12. Name James H McGivney
13. Birthplace Mass.

MOTHER 14. Maiden name Ellen Mealy
15. Birthplace Mass

16. Informant Jno. P Mahoney.
Address Brookline Mass.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-15-47 (month) (day) (year)

Cemetery or crematory Holy Rood
Location Brookline Mass.

18. Funeral director J.C. Higinbotham
Address Ellicott City Md

19. May 13, 1947 (Date rec'd by registrar) John B. Long Pub. H. Off. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10 19 47, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-10 19 47 to 5-10 19 47 and that I last saw h 1m alive on no date 19

Immediate cause of death Coronary occlusion — DURATION 4 hours

Due to

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none — Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Geo. E. Bugtag M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other

Address Ellicott City, Md. Date signed 5-11-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 04128

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Howard County
(b) Street address Hardman's Tourist Camp, Edmondson Ave + St. John's Lane
(c) Hospital or institution: Ellicott City, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Newington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 21, 1902

8. AGE: Years	Months	Days	If less than one day
44	7	2	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Advertising Salesman
11. Industry or business

FATHER
12. Name Joseph Rice
13. Birthplace Russia

MOTHER
14. Maiden Name Lena Gallun
15. Birthplace Russia

16 (a) Informant Mr Morton Robinsom
(b) Address 801 Newington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Mishkin Israel Cong
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) May 26-47 (Date rec'd by registrar) (b) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23- 1947, at 11 38 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home or farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl C. Reyer M.D.
Medical Examiner
Date signed

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

04129 P

CERTIFICATE OF DEATH

Reg. Dist. No. 9/

1. PLACE OF DEATH:
County HOWARD
City or town RURAL - ELLICOTT CITY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? SINCE APRIL 23rd 1947
Hospital, Institution, or street address where death occurred:
PINEL CLINIC - ELLICOTT CITY, MD.
How long in hospital or Institution? SINCE APRIL 23rd 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County BALTIMORE
City or town LOCH RAVEN MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. OLD HARFORD RD.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JACOB RYE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife Ernestena M. Rye
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCTOBER 1st 1878

8. AGE: Years 68 | Months 7 | Days 13 | If less than one day ..... hrs. ..... min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual occupation FARMER

11. Industry or business

FATHER
12. Name Geo. L. Rye
13. Birthplace Germany

MOTHER
14. Maiden name Anna C. Class
15. Birthplace Germany

16. Informant GEORGE L RYE
Address LOCH RAVEN MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/16/47 (month) (day) (year)
Cemetery or crematory Parkwood
Location Balto. Md.

18. Funeral director Lansdale Funeral Home
Address 7401 Belair Rd. Balto. Md.

19. May 14 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 13th 1947, at 8 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 23rd 1947, to MAY 13th 1947
and that I last saw h.i.m. alive on MAY 13th 1947

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	3 HOURS
Due to GENERALIZED ARTERIOSCLEROSIS	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Helmut Trager M.D.
M. D. or other
Address Ellicott City Md Date signed 5/13/47

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

2411 N. Charles

Permit

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Diat. No. 04195

1. PLACE OF DEATH:
County Howard (~~Prince George~~)
City or town Laurel Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred: North Harned
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: Howard
(For newborn infants give residence of mother)
State Maryland County (~~Prince George~~) Rural
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. North Harned
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clara Marie Smitherman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife George Smitherman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1869

8. AGE: Years	Months	Days	If less than one day
78	3	10	..... hrs. ..... min.

9. Birthplace Offard England
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name — Jones
13. Birthplace England
MOTHER 14. Maiden name — Jeles
15. Birthplace England
16. Informant Mrs. Alice Redmiles
Address Laurel Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23, 1947 (month) (day) (year)
Cemetery or crematory Meadow Hill Cemetery
Location Laurel, Maryland
18. Funeral director Elliott Mundhenk
Address Laurel Maryland
19. 5/23/47 19..... Frank Shipley Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947 at 4:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1929 to May 21 1947 and that I last saw h[illegible] alive on May 20 1947

	DURATION
Immediate cause of death Acute myocarditis	1 day
Due to Chronic Myocarditis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert J. McEnery M. D. or other
Address 402 Main St Laurel Md Date signed 5-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Howard
City or town Hanover
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Howard
City or town Hanover
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Arthur Tilden Wolfenden

3.(b) Social Security Number 217-01-1644

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Susan A Wolfenden
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) Aug 23 1876
8. AGE: Years 70 Months 8 Days 22 If less than one day ....hrs. ....min.
9. Birthplace Guilford, Howard Co Md.
(Town, county, and state)
10. Usual occupation Book keeper
11. Industry or business [illegible]
FATHER 12. Name Jas T Wolfenden
13. Birthplace "
MOTHER 14. Maiden name Annie Handle
15. Birthplace unknown
16. Informant Mrs Susan A Wolfenden (wife)
Address Hanover Md.
17. Burial Date thereof May 17, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Western
Location Baltimore, Md.
18. Funeral director G. Howard Strong
Address 3207 W. North Ave.
19. 5/15 1947 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947, at 6:45 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1947, to May 15 1947
and that I last saw him alive on May 13 1947

Immediate cause of death	DURATION
acute coronary occlusion	1 day
c chr myocarditis	3 yrs
Due to General Arterio-	3 yrs
Due to sclerosis	
c chr Bronchitis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B B Brumbaugh M. D. or other
Address 5609 Main St Ellicott City Md Date signed 5/17/47

VS A15 9.45-15M

I T